Foreword

Substance Abuse: A Public Health Problem

Requiring Appropriate Intervention

Alcohol and drug abuse are major underlying contributors to health care costs, social problems such as crime, homelessness, spouse and child abuse, as well as on-the-job safety and productivity losses. Substance abuse is a driving force in America's (and Vermont's) health care crisis. Figures from the U.S. Department of Health and Human Services' Healthy People 2010[†] indicate the following:

- 9.5 cirrhosis deaths per 100,000 population occurred in 1998
- There were 5.9 Alcohol related deaths and 113 Alcohol related injuries per 100,000 population
- 6.3 drug-induced deaths per 100,000 population occurred in 1998
- 542,544 hospital emergency department visits were drug-related in 1998
    - Alcohol consumption is associated with a wide range of events that can result in ED visits—among them, motor vehicle crashes, violence, and alcohol poisoning. In 1996, alcohol-related hospital ED visits (2.2 million) accounted for 2.4 percent of all ED visits. Visits related to both alcohol and drugs accounted for an additional 0.4 percent. However, these figures, based on a national probability survey of hospital EDs, are probably underestimates because information on alcohol involvement often is missing from ED medical records
- Drugs, and most commonly alcohol, also are a factor in a significant number of firearm-related deaths.
- Two-thirds of victims who experienced violence by an intimate (a current or former spouse, boyfriend, or girlfriend) reported that alcohol had been involved. Among spousal victims, three out of four incidents involved an offender who was drinking
- The economic cost of alcohol and drug abuse in the United States was estimated at $276 billion for 1995, with about $167 billion attributed to alcohol abuse and $110 billion to drug abuse
- 2.18 gallons of ethanol per person aged 14 years and older were consumed in 1997.
- Alcohol problems, drug problems, and suicide attempts frequently cause ED visits, but these conditions may be overlooked during the visit or inadequately addressed when plans for followup are made. Some ED patients are treated for physical manifestations of alcohol problems, drug problems, or suicide attempts and released without appropriate evaluation, treatment, or referral for underlying behavioral risk factors that may cause a

repeat ED visit. These risk factors include hazardous patterns of alcohol consumption, use of illicit drugs, and predisposition to suicidal thoughts or actions. The effectiveness of ED interventions for these risk factors is determined by how well the affected patients are evaluated and treated in the ED and by the extent of communication and coordination with other settings and organizations in the community. EDs are strategically well positioned to ensure appropriate referrals for followup care, but underlying behavioral risk factors must be identified and appropriate followup services must be available. What Vermont has lacked is appropriate public health and safety crisis services to address this problem. This concept paper outlines the possible design of such a system.

† Available online at - http://www.healthypeople.gov/Document/HTML/Volume2/26Substance.htm

Background

In 1978 the Vermont Legislature enacted the Alcohol Services Act. This act decriminalized public intoxication and put in place a program to move public inebriates into treatment rather than into jail.

The law stated: *It is the policy* of *the state of Vermont that alcoholism and alcohol abuse are correctly perceived as health and social problems rather than criminal transgressions against the welfare and morals of the public.*

Within two years of its passage the bill produced results that were contrary to its intent. In 1977, the last full year prior to the legislation, 550 persons were jailed for public intoxication. By 1979, police intervened with, 1,013 persons and by 1980, 572 or 47% of those picked up by the police had gone to jail for their protection. Those numbers increase greatly from 1980 until 1991 when a total of 2,440 (60%) of persons entering the system were jailed. The increase in both total cases and incarcerations has remained fairly stable since 1991.

The increased use of the jail option came as local lock-ups were being closed due to liability issues and shelter space was declining. Substance abuse programs were unable to find shelter staff from the recovering community as they once had. This, combined with under funding caused many programs to lose shelters.

Presently, shelter is offered in only four areas of the state. In three of the areas the capacity is minimal. Where shelters exist better results (i.e. referrals to treatment) are achieved. Chittenden County's ACT One Program being the most notable.

For lack of appropriate shelter resources the housing burden fell on the community correctional centers at a time when their space was at a premium. Consequently, individuals with alcohol and associated health problems, but no pending charge, were placed in holding cells with accused criminals - the exact situation the law was trying to avoid.

The use of jails as a solution to a public health issue poses significant problems:

- Incapacitated persons can be belligerent, presenting a challenge to the corrections facility staff.
- Use of an isolation cell requires regular monitoring of persons ill due to substance abuse.
- The use of holding cells is inconsistent with appropriate health care practices.
- Any "use of force" with public inebriates must be documented by corrections staff resulting in lost time.
- The use of force, strip searches and isolation cells poses significant liability issues since these persons have not been charged with a crime.
- Inebriates frequently arrive at correctional facilities without an adequate medical evaluation therefore placing them at risk for negative health outcomes.

Background (cont.)
A legislative study report "The Design Of Future Corrections Policy" echoed these concerns saying: *the long-term goal of corrections policy should be to reduce, or at least not increase at current rates, the need for people to be in the custody of the Commissioner of Corrections.*

The report also found that : *The state agencies concerned should integrate the planning of all programs serving populations in which significant numbers of people are likely to become offenders, for the purpose of treating root social problems in a preventative and remedial manner.*

In 2001 the Vermont legislature amended the statute to include persons under the influence of drugs other than alcohol as well. This change added to the numbers of persons who could be intervened with under the statute and further complicated the treatment issues involved. Recent attempts to implement the revised law through training for program staff have raised more questions than were answered. It was apparent that the system needed to be revised.

This paper is a result of several meetings of a Public Inebriate Study Group that was formed to examine these issues and make recommendations to the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs.

It is the hope of this study group that hospital administrators, emergency rooms directors, police, domestic violence shelters, mental health centers, community correctional centers and homeless shelters. will indicate a willingness to form a new partnership with the state in building an effective system of care for chronic substance abusers.

Toward a New Solution

In 2004, the intent of this legislation is still valid; however, the 26 year-old program design no longer serves the best interests of either the target population or the public at large. We are still trying to solve a public health problem with a law enforcement solution. This approach in effect perpetuates the criminalization of public intoxication, contrary to the law's intent. The current legislation does not address changes in today's culture:

- Since 1978 it has become clear that chronic substance abusers are a key population at risk for the spread of various Infectious diseases. The spread of AIDS through IV Drug users is well documented. This population and other chronic abusers are also at risk for virulent diseases such as hepatitis and tuberculosis.

- The concurrent rise in the use of alcohol and drugs and the increased risk of the spread of disease in a correctional setting have only increased the need for a program that diverts these persons into treatment settings. The current system does not accomplish that goal - nearly two-thirds of the caseload end up in jail.

- The system now calls for law enforcement to be the primary intervention point as opposed to a public health orientation that sees the program as emergency care. The desired alternative would be multiple entry points to a service jointly operated by Department of Mental Health, ADAP, and health professionals that aids individuals and families in getting appropriate care.

The flaws in the current system have exposed several areas for legal and liability concern:

- The potential for misdiagnosis ;
- Inadequate medical screening and care; and
- Potential for harm (to self-and others) i.e. domestic violence or suicide cases.

Resources continue to be the most challenging aspect of providing adequate services to the population served through the Public Inebriate Program.

Developing the New System

Key Principles

Any new system should:

- Recognize that persons incapacitated by alcohol or other drugs reflect a public health problem.
- Be both a public health and safety program.
- Have multiple entrance points, e.g. police intervention, family, ER, other community services.
- Provide services in an accessible and professional environment with a respectful approach toward providing safety, intervention and resources directed toward recovery.
- Be delivered as health care and eligible for reimbursement under private insurance as well as Medicare/ Medicaid and fee for service.
- Require medical screening as needed for the health and safety of the client. (This will require the development of tools to determine what level of medical screening is needed.)
- Have sufficient shelter and other appropriate resources to meet the needs within the community.
- Result from a collaborative relationship between community stakeholders, in partnership with the state, in both design and funding.
- Be part of a multiple human service response that can deal with issues such as domestic violence, suicidal risk and child protection.
- Incarcerate only those incapacitated** individuals with lodgeable offenses, or who are refusing services.
- Be supported by a statute grounded in the above principles.

Outcomes

Current System	**Proposed system**
Public Inebriates are a law enforcement problem	Substance abusers are a public health and safety problem.
Entrance through police intervention only	Multiple entrance points, including other emergency services.
Inadequate shelter and detox facilities	Adequate care and housing of incapacitated persons. including medical beds-
Health services are an adjunct to the program.	System has a health care focus for individuals and families
Majority of individuals spend night in jail	Majority of individuals spend night in appropriate level of supervised shelter
Incapacitation response seen as "drunk-tank".	Emergency response is attractive to individuals and families
Public Inebriates placed at medical risk.	Impaired individuals placed in medical safety.
State/Law Enforcement assumption of responsibility, no clear accountability.	Clear community partnership in medically based response.
Liability for all parties from misdiagnosis and inappropriate treatment.	Reduced liability
Persons placed in jail for "protection" with no treatment follow-up	Placement in medically based shelters with strong connection and referral to substance abuse treatment.
Inadequate resources hamper effectiveness.	Cost effective and efficient.
High risk of communicable diseases spread in correctional facilities and shelters.	Medical screening for communicable
Delivered services non-reimbursable.	Delivered health care services reimbursed under Private insurance/ Medicaid
Incarceration of non-offenders	Incarceration of only criminally charged offenders.

The Essential Components

Recommended Model

- Emergency services for substance abuse is not a correctional issue and should be based on a public health model.

- Emergency services for substance abuse should be jointly resourced by the hospitals, approved substance abuse programs and other area stakeholders. These services may include, but are not limited to:

    - Substance abuse screening and assessment
    - Medical evaluation and treatment
    - Appropriately staffed shelter
    - Referral for needed services
    - Transportation services

- Access to the emergency substance abuse services system will be prominently publicized and will include information about methods of access.

- Emergency services for substance abuse should be available to all persons in need.

- There will be adequate personnel and physical resources available for emergency services for substance abuse.

- Appropriate shelter will be supported cooperatively by the hospital and the substance abuse program.

- Training and maintenance of the substance abuse assessment team and shelter staff will be done by the area substance abuse program designated to manage the service.

- Prior to release from shelter, the program will provide an active intervention in the form of information and referral services and limited case management to each client.*

- Medically managed detoxification facilities will be available on a regional basis.

- In the case of police interventions, jail referrals will be used only when someone has been medically screened and can be charged with a jailable offense.**

* The committee believes that this recommendation represents the best opportunity for engaging the client and assisting them to access appropriate substance abuse services.

**The committee understands that the current law allows people to be placed in protective custody under the supervision of the DOC. This provision will need to be revised in order to move addictions emergency services into a public health model. While it is important to retain

the capacity for protective custody by a police officer in order to transport an individual to a safe and secure location, we believe that jail is never an appropriate placement for these individuals.